Canada/Netherlands Agreement

Applying for a Dutch invalidity benefit

Here is some important information you need to consider when completing your application.

Please ensure you sign the application. If you are signing with a mark, (for example: “X”) the signature of a witness is required.

Your application must be supported by documentation. Please submit the documents requested. Failure to complete the application and provide the requested documentation may result in delays in processing your application.

Where original documents are specifically requested, originals must be submitted with your application. You should keep a certified true copy of any originals you send us for your records. Some countries require original documentation which will not be returned to you.

You may submit the original or a photocopy that is certified as true for any of the documents where originals are not required. It is better to send certified copies of documents rather than originals. If you choose to send original documents, send them by registered mail. We will return the original documents to you. We can only accept a photocopy of an original document if it is legible and if it is a certified true copy of the original. Our staff at any Service Canada centre will photocopy your documents and certify them free of charge. If you cannot visit a Service Canada Centre, you can ask one of the following people to certify your photocopy:

Accountant; Chief of First Nations Band; Commissioner for Oaths; Employee of a Service Canada Centre acting in an official capacity; Funeral Director; Justice of the Peace; Lawyer, Magistrate, Notary; Manager of Financial Institution; Medical and Health Practitioners: Chiropractor, Dentist, Doctor, Naturopathic Doctor, Nurse Practitioner, Ophthalmologist, Optometrist, Pharmacist, Psychologist, Registered Nurse; Member of Parliament or their staff; Member of Provincial Legislature or their staff; Minister of Religion; Municipal Clerk; Official of a federal government department or provincial government department, or one of its agencies; Official of an Embassy, Consulate or High Commission; Officials of a country with which Canada has a reciprocal Social Security Agreement; Police Officer; Professional Engineer; Social Worker; Teacher, University Professor.

People who certify photocopies must compare the original document to the photocopy, state their official position or title, sign and print their name, give their telephone number and indicate the date they certified the document.

They must also write the following statement on the photocopy: **This photocopy is a true copy of the original document which has not been altered in any way.**

If a document has information on both sides, both sides must be copied and certified. You cannot certify photocopies of your own documents, and you cannot ask a relative to do it for you.

Return your completed application, forms and supporting documents to:

International Operations
Service Canada
P.O. Box 250
Fredericton NB E3B 4Z6
CANADA

Disclaimer:

This application form has been developed by external sources in cooperation with Employment and Social Development Canada. The content and language contained in the form respond to the legislative needs of those external sources.

Agreement on Social Security between Canada and the Kingdom of the Netherlands

Accord de sécurité sociale entre le Canada et le Royaume des Pays-Bas

Verdrag inzake sociale zekerheid tussen het Koninkrijk der Nederlanden en Canada

Investigation of a claim for Dutch invalidity benefits [1]

Instruction d'une demande de prestations d'invalidité des Pays-Bas

Behandeling van een aanvraag om Nederlandse invaliditeitsuitkering

1. Information concerning the claimant - *Renseignements sur le requérant* - Inlichtingen betreffende de aanvrager

Canadian Social Insurance Number
Numéro d'assurance sociale du Canada
Canadees sociaal verzekeringsnummer _____

Dutch registration number (if known)
Numéro d' enregistrement aux Pays-Bas (s'il est connu)
Nederlands registratienummer (indien bekend) _____

Family name
Nom de famille
Naam _____

Family name at birth
Nom de famille à la naissance
Geboortenaam _____

Given name(s)
Prénom(s)
Voorna(a)m(en) _____

Date of birth
Date de naissance
Geboortedatum Day/*Jour*/Dag _____ Month/*Mois*/Maand _____ Year/*Année*/Jaar _____

Sex
Sexe
Geslacht ☐ Male *Masculin* Man ☐ Female *Féminin* Vrouw

Nationality
Nationalité
Nationaliteit _____

Language Preference [2]
Langue préférée pour la correspondance
Voorkeurstaal ☐ English *Anglais* Engels ☐ French *Français* Frans ☐ Dutch *Néerlandais* Nederlands

Marital Status
état civil
Burgerlijke staat ☐ Single *Célibataire* Ongehuwd ☐ Married *Marié(e)* Gehuwd ☐ Divorced *Divorcé(e)* Gescheiden ☐ Separated *Séparé(e)* Gescheiden levend ☐ Living together *Conjoint(e) de fait* Samenwonend

Home address - *Adresse du domicile* - Hulsadres [3]

Street
Rue
Straat _____ Number *Numéro* Nummer _____ City *Ville* Plaats _____

Postal *Code*
Code *Postal*
Postcode _____ Province *Province* Provincie _____ Country *Pays* Land _____

Telephone number
Numéro de téléphone
Telefoonnummer _____

Mailing address (if different from above)
Adresse postale (si différente de l'adresse du domicile)
Postadres (ingeval dit afwijkt van huisadres)

Street
Rue
Straat _____ Number *Numéro* Nummer _____ City *Ville* Plaats _____

Postal Code
Code Postal
Postcode _____ Province *Province* Provincie _____ Country *Pays* Land _____

Telephone number
Numéro de téléphone
Telefoonnummer _____

2. I became incapable of work on
Je suis incapable de travailler depuis le
Ik ben arbeidsongeschikt geworden op
Day/*Jour*/Dag _____ Month/*Mois*/Maand _____ Year/*Année*/Jaar _____

3. On that day I was engaged in
à cette date
Op die dag was ik werkzaam
☐ paid employment
j' occupais un emploi rémunéré
in loondienst
☐ self-employment
je travaillais à mon compte
als zelfstandige

4. Occupation [4]
Emploi
Beroep _____

5. Gross annual earnings from paid employment [5]
Gains annuels bruts provenant de l'emploi rémunéré
Bruto jaarinkomen uit arbeid in loondienst _____

6. Gross annual earnings from self-employment [6]
Gains annuels bruts provenant de l'emploi autonome
Bruto jaarinkomen uit arbeid als zelfstandige _____

7. The incapacity for work
Mon incapacité de travail
De arbeidsongeschiktheid
☐ has *a été* is
☐ has not *n'a pas été* is niet
been caused by a third party [7]
causé par un tiers
veroorzaakt door een derde

8. Information concerning present occupational activities (if any).
Renseignements sur les activités professionnelles actuelles
Gegevens omtrent eventuele huidige werkzaamheden

☐ After commencement of the incapacity for work I did not follow occupational retraining courses
Après être devenu(e) incapable de travailler, je n'ai pas suivi de cours de recyclage professionnel.
Na de aanvang van de arbeidsongeschiktheid heb ik geen omscholingscursussen gevolgd.

☐ After commencement of the incapacity for work I followed retraining courses in: [8]
Après être devenu(e) incapable de travailler, j' ai suivi des cours de recyclage professionnel.dans le domaine suivant:
Na de aanvang van de arbeidsongeschiktheid ben ik omgeschoold tot: _____

I am
à l'heure actuelle
Ik

☐ not engaged in occupational activites.
je ne travaille pas.
verricht geen beroepswerkzaamheden

☐ engaged in paid employment for _____ hours daily.
j'occupe un emploi rémunéré _____ *heures par jour.*
verricht arbeid in loondienst op _____ uren per dag.

☐ engaged in self-employment for _____ hours daily.
je travaille à mon compte _____ *heures par jour.*
verricht arbeid als zelfstandige op _____ uren per dag.

Name of present employer
Nom de l'employeur actuel
Naam van huidige werkgever _____

Address
Adresse
Adres _____

Type of work presently pursued
Nature du travail
Aard van de huidige werkzaamheden _____

Date of commencement of work presently pursued
Date d'entrée en fonction
Aanvangsdatum van de huidige werkzaamheden
Day/*Jour*/Dag _____ Month/*Mois*/Maand _____ Year/*Année*/Jaar _____

Earnings from work presently pursued [9]
Gains provenant de l'emploi actuel
Inkomen uit de huidige werkzaamheden _____
☐ weekly *par semaine* per week
☐ monthly *par mois* per maand

9. Information relating to the claimant's residence and work history. 10
Renseignements sur les lieux de résidence et les antécédents professionnels du requérant.
Gegevens omtrent woontijdvakken, tijdvakken van volgen van een opleiding en het arbeidsverleden van aanvrager.

Period *Période* Tijdvak From/To *Du/Au* Van/Tot	Type of period 11 *Catégorie de la période* Aard van de periode	City and country of residence *Ville et pays de résidence* Woonplaats en woonland	City and country of employment *Ville et pays de travail* Plaats van arbeid en werkland	Social insurance institution 12 *Organisme d'assurance sociale* Sociaal verzekerings-orgaan	Social insurance number *Numéro d'assurance sociale* Sociaal verzekerings-nummer	Type 13 *Type d'assurance* Aard

10. Information concerning claimant's household 14
Renseignements sur le ménage du requérant
Gegevens omtrent het huishouden van aanvrager

I am
Je
Ik

☐ living alone
vis seul(e)
ben alleenstaande

☐ maintaining a common household with:
partage un ménage avec:
voer een gemeenschappelijk huishouden met:

Family name
Nom de famille
Naam _____

Given name(s)
Prénom(s)
Voorna(a)m(en) _____

Date of birth
Date de naissance
Geboortedatum Day/*Jour*/Dag _____ Month/*Mois*/Maand _____ Year/*Année*/Jaar _____

The above mentioned
La personne susmentionnée
Bovengenoemde

☐ is not pursuing an occupational activity
n'occupe pas d'emploi
verricht geen beroepswerkzaamheden

☐ is pursuing an occupational activity
occupe un emploi
verricht beroepswerkzaamheden

Annual gross amount of earnings from the occupational activity.
Gains annuels brut provenant de l'emploi.
Brutojaarbedrag van de inkomsten uit beroepswerkzaamheden

_____

Children belonging to my household:
Enfants appartenant au ménage:
Tot het huishouden behorende kinderen:

Family name *Nom de famille* Naam	Given name(s) *Prénom(s)* Voorna(a)m(en	Date of birth *Date de naissance* Geboortedatum	Relationship [15] *Liens* Verwantschap	Attending school *Aux études* Schoolgaand	Occupation *Emploi* Beroep

11. Declarations/Déclaratons/Verklaringen

I, the claimant, hereby apply for invalidity benefits and a supplementary allowance under Dutch law (aaw/wao and tw) I completed this application form as completely as possible and declare that the given information is true.

Par la présente, je demande à recevoir des prestations d'invalidité et une allocation supplémentaire en vertu de la loi néerlandaise (aaw/wao et tw).
J'ai rempli le formulaire avec le plus de précision possible et je certifie que les renseignements que j'ai fournis sont véridiques.

Hiermede doe ik een aanvraag voor aaw/wao-uitkering en een toeslag ingevolge de "Toeslagenwet".
Dit aanvraagformulier is door mij zo volledig mogelijk en naar waarheid ingevuld.

I hereby authorize the Canadian competent institution to disclose information contained in their records to the competent Dutch institution for the purpose of determining whether I am eligible for a Dutch invalidity benefit.

Par la présente, j'autorise l'établissement canadien compétent à divulguer les renseignements contenus dans leurs dossiers à l'établissement néerlandais compétent qui déterminera si je suis admissible aux prestations d'invalidité des Pays-Bas.

Hierbij machtig ik de bovengenoemde Canadese instelling om de informatie waarover dit orgaan beschikt toe te zenden aan de bevoegde Nederlandse instelling opdat deze instelling kan beoordelen of ik in aanmerking kom voor een Nederlandse invaliditeitsuitkering.

Signature
Signature
Handtekening

City
Ville

Date
Date
Datum

I have, in accordance with Article 5 par. 3 of the administrative arrangement, verified the information given by the claimant.

En vertu du paragraphe 3 de l'article 5 de l'arrangement administratif, j'ai vérifié les renseignements fournis par le requérant.

Ik heb de door de aanvrager verstrekte informatie overeenkomstig artikel 5, lid 3 van het administratief akkoord geverifieerd.

International Operations Division
Income Security Programs
Human Recources Development Canada
Ottawa, Ontario K1A OL4

Stamp and signature
Cachet et signature
Stempel en handtekening

Date
Date
Datum

Notes - Notes - Noten

1. This application form is to be used for claming Dutch invalidity benefits and supplementary allowances under the Canadian-Dutch agreement on social security.
   It is an offence under Dutch law to make a false or misleading statement on this application.
   Ce formulaire sert à demander des prestations d'invalidité et des allocations supplémentaires des Pays-Bas en vertu de l'accord de sécurité sociale établi entre le Canada et les Pays-Bas.
   Toute déclaration fausse ou trompeuse faite dans la présente demande constitue un délit aux termes de la loi néerlandaise.
   Dit formulier dient gebruikt te worden voor het met toepassing van het Nederlands - Canadees verdrag inzake de sociale zekerheid aanvragen van een Nederlandse invaliditeitsuitkering op grond van de aaw en/of wao en een toeslag ingevolge de Toeslagenwet.
   Volgens Nederlands recht pleegt u een misdrijf indien u op deze aanvraag valse of misleidende verklaringen aflegt.

2. Please indicate the language in which you wish to receive your correspondence.
   Please note that the official decision on your application for invalidity benefits and supplementary allowances must be issued in the Dutch language. You will however receive a summary of that decision in the language you requested.
   Veuillez préciser dans quelle langue vous aimeriez recevoir votre correspondance. La décision officielle relative à votre demande de prestations d'invalidité et d'allocations supplémentaires doit être émise en néerlandais, mais vous en recevrez un résumé dans la langue que vous aurez choisie.
   Gelieve aan te geven in welke taal u de correspondentie wilt ontvangen. Wij maken u er op attent dat de officiële beslissing op uw aanvraag om Nederlandse uitkeringen in het Nederlands gesteld moet zijn. Bij die beslissing ontvangt u een uittreksel in uw voorkeurstaal.

3. For verification purposes you must provide an official document indicating your home address.
   Aux fins de vérification, veuillez fournir un document officiel où figure votre adresse actuelle.
   In verband met de verificatie moet u een officieel document overleggen, waarop uw huisadres vermeld is.

4. Please indicate your occupation as precisely as possible.
   Veuillez indiquer la nature de votre emploi avec le plus de précision possible.
   Vermeld uw beroep zo nauwkeurig mogelijk.

5. For verification purposes you must provide your pay-slips covering 12 months preceding the date of commencement of your incapacity for work.
   Aux fins de vérification, vous devez fournir les talons de paye des douze mois qui précèdent la date du début de votre incapacité de travail.
   In verband met de verificatie moet u uw loonstroken over de 12 maanden voorafgaande aan het intreden van uw arbeidsongeschiktheid overleggen.

6. For verification purposes you must provide your notice of assessment from "Reveneu Canada Taxation" covering the 12 months preceding the date of commencement of your incapacity for work.
   Aux fins de vérification, vous devez fournir l'avis de cotisation de Revenu Canada - Impôt pour les douze mois qui précèdent la date du début de votre incapacité de travail.
   In verband met de verificatie moet u het aanslagbiljet van "Revenue Canada Taxation" over de 12 maanden voorafgaande aan het intreden van uw arbeidsongeschiktheid overleggen.

7. When your incapacity for work has been caused by a third party you must attach full details, including the name and address of that third party. These details should be provided on a separate sheet of paper.
   Si votre incapacité de travail a été causée par un tiers, vous devez donner des détails sur la situation, notamment le nom et l'adresse du tiers. Ces renseignements doivent être présentés sur une autre feuille.
   Indien de arbeidsongeschiktheid veroorzaakt is door een derde, dient u in een bijlage een volledige beschrijving aan te geven inclusief de naam en het adres van die derde.

8. Please provide details.
   Veuillez donner des précisions à ce sujet.
   Gelieve nadere bijzonderheden aan te geven.

9. For verification purposes you must provide your most recent pay-slips or Notice of Assessment from Revenue Canada Taxation.
   Aux fins de vérification, vous devez fournir les talons de paye ou l'avis de cotisation de Revenu Canada - Impôt les plus récents.
   In verband met de verificatie moet u de laatst ontvangen loonstroken of belastingformulieren overleggen.

10. Please provide in chronological order a full description of all periods of residence or employment since the age of 18. In the case of periods of school attendance or vocational training you must specify the type of schooling or training and the diplomas received.
Veuillez faire une description chronologique détaillée des lieux où vous avez habité et des emplois que vous avez eus depuis l' âge de 18 ans. Si vous étiez aux études ou en formation pendant un certain temps, précisez la nature de vos études ou de votre formation et les diplômes que vous avez reçus.
U dient een chronologisch overzicht te geven van alle tijdvakken van wonen of werken vanaf het bereiken van de 18-jarige leeftijd. Bij school- en beroepsopleidingen dient u de aard van de opleidingen en de behaalde diploma's aan te geven.

11. Please indicate if the period in question was a period of residence, period of employment or a period of schooling.
Veuillez préciser s'il s'agit d'une période de résidence, d'emploi ou d'études.
Gelieve het type tijdvak aan te geven; woontijdvak, arbeidstijdvak, tijdvak waarin een opleiding gevolgd is.

12. Please provide the name and the address of the social security institution.
Veuillez donner le nom et l'adresse de l'organisme de sécurité sociale.
Gelieve volledige informatie te verstrekken omtrent naam en adres van het sociaal verzekeringsorgaan.

13 Please indicate the type of insurance: A = compulsory, B = voluntary.
Veuillez préciser le type d'assurance : A = assurance obligatoire, B = assurance facultative.
Gelieve de soort verzekering aan te geven: A = verplicht, B = vrijwillig.

14. This information is necessary to determine your possible entitlement to supplementary allowances according to the "Toeslagenwet" and to determine your tax group. If you do not provide this information you will not be entitled to supplementary allowances and you will be classifed in the highest tax group.
Cette section aidera les autorités compétentes à décider si vous avez droit aux allocations supplémentaires en vertu du "Toeslagenwet" et à déterminer à quel groupe vous appartenez sur le plan fiscal. Si vous ne la remplissez pas, vous n'aurez pas droit aux allocations supplémentaires et vous serez classé dans le groupe le plus imposé.
Deze informatie is noodzakelijk in verband met de toeslagenwet en belastingheffing. Indien u deze informatie niet verstrekt heeft u geen recht op een toeslag ingevolge de toeslagenwet en wordt u in de hoogste belastinggroep ingedeeld.

15 1 = natural child, 2 = legally adopted child, 3 = foster child.
1 = enfant naturel, 2 = enfant adopté légalement, 3 = enfant placé.
1 = eigen kind, 2 = geadopteerd kind, 3 = pleegkind.

Canada/Netherlands Agreement

Documents and/or information required to support your application [CAN/NL 204] for a Dutch invalidity benefit

Complete the attached forms:

- **CAN/NL 216** completed by your employer
- ***Medical Report*** **[ISP 5052],** ***Questionnaire for Disability Benefits*** **[ISP 5050]** and ***Consent for Service Canada to Obtain Personal Information*** **[ISP 5051/5060]** if you have never applied for a Canada Pension Plan disability benefit

Originals or certified copies to be submitted for you and your partner or the person living with you:

- Birth certificate
- Marriage certificate (if applicable)
- Proof of nationality
- Valid photo identification document such as a current passport, driver's license, government issued ID card, etc.

Original or certified documents to be submitted for you:

- Proof of your home address (verified from an official document)
- Bank account details
- Proof of your employment during the last 12 months prior to becoming incapacitated for work (such as: pay slips, Notice of Assessment from the Canada Revenue Agency, etc.)

IMPORTANT: If you have already submitted any of the documents required when you applied for a Canada Pension Plan or Old Age Security benefit, you do not need to resubmit them.

CAN/NL 216

This form is to assist the GAK in order to calculate the amount of Dutch invalidity benefit.
Ce formulaire a pour but d'aider le GAK à calculer le montant de la prestation d'invalidité des Pays-Bas.

1. Name
Nom _____

Date of birth
Date de naissance _____

2. Indicate the employee's salary (including all bonuses, commissions etc.) for the 12 month period immediately preceding the date of work cessation resulting from incapacity
Indiquez la salaire de l'employé (y compris toutes les primes, les commissions, etc.) pour la période de 12 mois précédant immédiatement la date où l'employé a cessé de travailler en raison d'une incapacité. _____

3. During the above-mentioned period the employee worked:
Au cours de la période susmentionnée, l'employé a travaillé:

from *de* _____ to *à* _____ (specify dates) *(précisez les dates)*

type of occupation
genre d'emploi _____

4. *a.* In case of fixed wages: indicate the gross amount of monthly wages for the month immediately preceding work cessation (excluding emoluments such as overtime pay/holiday allowance):
En cas de traitement fixe: indiquez le montant brut du salaire mensuel pour le mois précédant immédiatment la cessation d'emploi (à l'exclusion des émoluments, comme par exemple la rémunération des heures supplémentaires ou les indemnités de vacances): _____

b. In case of variable wages: indicate the gross amount of wages for the 12 month period above-mentioned (excluding emoluments such as overtime pay/holiday allowance):
En cas de traitement variable: indiquez le montant brut du salaire pour la période de 12 mois susmentionnée (à l'exclusion des émoluments, comme par exemple la rémunération des heures supplémentaires ou les indemnités de vacances): _____

5. The person concerned use to work _____ hours per week *heures par semaine* ☐ full-time *à temps plein* ☐ part-time *à temps partiel*
La personne en question travaillait

6. During the above-mentioned 12 month period, the following amounts were paid:
Au cours de la période susmentionnée de 12 mois, les montants suivants ont été versés:

Holiday allowance
Indemnité de vacances _____

Christmas bonus
Prime de Noël _____

Overtime
Temps supplémentaire _____

Number of hours of overtime
Nombre d'heures supplémentaire _____

Other (specify)
Autres (précisez) _____

7 Period for which no salary was paid to the person concerned:
Période pendant laquelle aucun salaire n'a été versé à la personne en question:
from *de* _____ to *à* _____
from *de* _____ to *à* _____
from *de* _____ to *à* _____

8 Gratifications/bonuses /profit sharings received over the last three years prior to the incapacity for work:
Gratifications/primes/participation aux beénéfices reçues au cours des trois dernières années avant que l'employé ne cesse de travailler en raison d'une incapacité:
19 ____ = _____ description _____
19 ____ = _____ description _____
19 ____ = _____ description _____

9. Had the employee contined working, what would the estimated amount of wages have been 12 months following the actual cessation of employment?
Si cet employé avait continué à travailler, quel aurait-été le montant approximatif de son salaire 12 mois après la cessation réele de l'emploi?

10. Indicate the date on which Canada Pension Plan contributions were last made:
Indiquez la date à laquelle l'employé a versé des cotisations au Régime de pensions du Canada pour la demière fois:

Name and address of employer
Nom et adresse de l'employeur

Date
Date

Authorized signature
Signature de la personne autorisée

MEDICAL REPORT

SECTION A - To be completed by Applicant			
First Name and Initial	Last Name		
Home Address (No., Street, Apt. No., P.O. Box, R.R.)	City, Town or Village		
Province or Territory	Country	Postal Code	
Telephone number	Date of Birth (Year Month Day)	Canadian Social Insurance Number	

SECTION B - To be completed by Physician			
Please provide factual objective opinions			
1. Height Weight	2 a) How long have you known the patient?	b) When did you start treating the patient for the main medical condition? Year Month	c) Date of last visit Year Month Day

3. Diagnosis(es)

4. Relevant/significant medical history relating to the main medical condition:

Please write legibly

Service Canada delivers Employment and Social Development Canada programs and services for the Government of Canada

Canadian Social Insurance Number:

5. Over the past two years, has the patient been admitted to a hospital/institution?

☐ Yes **If yes,** please list:

☐ No

Name of the Hospital(s)/Institution(s)

The date(s) of admission Year Month Day	The reason(s) for admission
_____	_____
_____	_____
_____	_____

6A. Is there supporting evidence for the main medical condition? Please attach supporting documentation.

Laboratory Reports	☐ Yes	☐ No
X-ray reports	☐ Yes	☐ No
Consultants' opinions	☐ Yes	☐ No
Other	☐ Yes	☐ No
Documentation to be returned	☐ Yes	☐ No

6B. Please describe relevant physical findings and functional limitations.

Please write legibly

Canadian Social Insurance Number:

7. Are further consultations or medical investigations planned relating to the main medical condition?

☐ Yes **If yes,** please specify:

☐ No

8. Is the patient currently on medication(s) as a result of the main medical condition?

☐ Yes **If yes,** please indicate dosage and frequency.

☐ No

9. Treatment: List type and response.

Please write legibly

Canadian Social Insurance Number:

FOR OFFICE USE ONLY		
☐ A.C.	Initials	Year Month Day

10. Prognosis of the main medical condition of this patient:

11. Additional Information

SIGNATURE (Please print or use a stamp)

Physician's Full Name

Address

Postal Code

☐ Family Physician

☐ Nurse Practitioner

☐ Specialty _____

Signature X	Year Month Day	Telephone No.

Please write legibly

QUESTIONNAIRE FOR DISABILITY BENEFITS CANADA PENSION PLAN

1. **FIRST NAME AND INITIAL**	**LAST NAME**	**SOCIAL INSURANCE NUMBER**

EDUCATION

2. What was the highest grade you completed in school?

Have you attended college or university?

◯ Yes **If yes**, indicate number of years and/or diploma/degree obtained.

◯ No

3. Have you ever been involved in any technical, trade, or on the job training?

◯ Yes **If yes**, provide the following details:

◯ No

Dates	Type of program	Certificate obtained

WORK HISTORY (BE SURE TO INCLUDE WORK DONE IN CANADA AND/OR OTHER COUNTRIES)

EMPLOYEE

4. Have you stopped working completely?

◯ Yes, go to question 5.

◯ No, provide the following information:

Type of Work

☐ Full-time ☐ Part-time ☐ Volunteer ☐ Seasonal

Number of hours per day	Number of days per week	If seasonal, explain period(s) of work	Salary per hour	/or per day	/or per year

5. If you have stopped working completely, provide the following information:

What kind of work did you do in your most recent job?

Why did you stop working?	Date employment started (YYYY-MM-DD)	**Last day on the job** (YYYY-MM-DD)

6. Name and full address of your present or most recent employer.

SELF - EMPLOYED

7. If you are or were self-employed, provide the following information:

a) Date business started (YYYY-MM-DD)

b) When did you actually stop working in the business? (YYYY-MM-DD)

c) Why did you stop working in the business?

d) Describe the business operation

e) What was your involvement with the business?

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SELF - EMPLOYED (CONTINUED)

f) Are you involved in the business in any way at the present time?

◯ Yes, explain your present involvement.
◯ No, provide the following information:

Indicate what disposition has been made for the business:

◯ sold ◯ rented ◯ profit sharing Date of disposition (YYYY-MM-DD)

If **no disposition** has been made of the business, how does it operate now and what arrangements are you contemplating in the future?

g) What was the last year that an income tax return on the operation of the business was filed in your name?

h) Will you declare yourself a self-employed person for income tax purposes this year?

◯ Yes ◯ No

OTHER WORK HISTORY

IF THERE IS INSUFFICIENT SPACE TO LIST ALL YOUR OTHER TYPES OF WORK, USE THE SPACE AT THE END OF THIS QUESTIONNAIRE.

8. In the past two years, did you do **any other work** in addition to your main job (such as part-time farming, night or other employment)?

◯ Yes **If yes**, provide the following details:
◯ No

Type of work	Number of hours per day	Number of hours per week	Work started (YYYY-MM-DD)	**Last day on the job** (YYYY-MM-DD)

Name and full address of employer

9. Have you done **any other type of work** in the last five years?

◯ Yes **If yes**, list the type of work and the dates.
◯ No

	From			To		
	Year	Month	Day	Year	Month	Day

10. Because of your medical condition, did you have to do a lighter job or a different type of work?

◯ Yes **If yes**, please describe.
◯ No

11. Has your physician told you when you can return to work?

◯ Yes **If yes**, give the date: (YYYY-MM)
◯ No

12. Do you plan to return to work or seek work in the near future?

◯ Yes **If yes**, answer **one** of the following questions:
◯ No

a) The date you plan to **return** to your former employer/employment (YYYY-MM)	b) The date you will **start** a new job. (YYYY-MM)	c) The date you plan to start looking for work. (YYYY-MM)

OTHER BENEFITS

13. If you are receiving any form of accident or illness/disability benefits, state the name of the insurance company

14. If any of your health problems are covered by Provincial workers' compensation benefits, provide details in each case.

Claim Number	Province or Territory	Year	Injury

State type of benefit you now receive.		Percentage of pension awarded
15. Have you received regular Employment Insurance benefits in the last two years? ◯ **Yes** **If yes**, give the dates: ◯ No	From (YYYY-MM-DD)	To (YYYY-MM-DD)
	From (YYYY-MM-DD)	To (YYYY-MM-DD)

MEDICAL INFORMATION

16. **When could you no longer work because of your medical condition?**	(YYYY-MM-DD)

17. Height	Weight	◯ Right-handed ◯ Left-handed

18. State the illnesses or impairments that prevent you from working. If you do not know the medical names, describe in your own words.

19. Describe how these illnesses or impairments prevent you from working.

20. If you have other health-related conditions or impairments, please describe them.

21. If you had to stop other activities (such as hobbies, sports or volunteer work), please explain and give dates activities ceased.

22. Explain any difficulties/functional limitations you have with the following:	
Sitting/Standing (How long?)	Seeing/Hearing
Walking (How long and how far?)	Speaking
Lifting/Carrying (How much and how far?)	Remembering
Reaching	Concentrating
Bending (How much?)	Sleeping
Personal needs (Eating, washing hair, dressing, etc.)	Breathing
Bowel and bladder habits	Driving a car (How long?)
Household maintenance (Cooking, cleaning, shopping and similar activities)	Using public transportation

INFORMATION ABOUT YOUR PHYSICIANS

23. Provide the following information about the physician who will be completing your medical report.

Physician's Full Name ◯ Family Physician ◯ Specialist (Please specify)

Address	City

Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number

When did you first see this physician? (YYYY-MM) | When was your last visit? (YYYY-MM)

What were the reasons for your visits?

24. List all other physicians you have seen in the last two years (space for two physicians is provided). If there is insufficient space to list all of your physicians, use the space at the end of this questionnaire.

a) Physician's Full Name Specialty

Address	City

Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number

When did you first see this physician? (YYYY-MM) | When was your last visit? (YYYY-MM)

Were your visits related to your present medical condition? ◯ Yes **If yes**, explain the reasons for your visits. ◯ No

b) Physician's Full Name Specialty

Address	City

Province or Territory	Country (If other than Canada)	Postal Code	Telephone Number

When did you first see this physician? (YYYY-MM) | When was your last visit? (YYYY-MM)

Were your visits related to your present medical condition? ◯ Yes **If yes**, explain the reasons for your visits. ◯ No

HOSPITALIZATION

25. If you have been admitted to hospital in the last two years, please provide the following information. Space for two hospitals is provided. If there is insufficient space to list all of the hospitals, use the space at the end of this questionnaire.

a) Name of hospital | Mailing address (No., Street, P.O. Box, R.R.)

City	Province or Territory	Country (If other than Canada)	Postal Code

Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician

Reason for admission and type of treatment

b) Name of hospital | Mailing address (No., Street, P.O. Box, R.R.)

City	Province or Territory	Country (If other than Canada)	Postal Code

Date admitted (YYYY-MM-DD)	Date discharged (YYYY-MM-DD)	Name of attending physician

Reason for admission and type of treatment

MEDICATION AND TREATMENT

26. List any medication you now take.

Name of medication	Dosage	How often

27. Describe other treatment you receive (such as counselling, physiotherapy).

28. If future treatments or medical tests are planned, please explain, giving dates.

29. List any medical devices you use (such as crutches, cane, artificial limb, splints, braces, wheelchair, hearing aid, heart pacemaker, ostomy apparatus).

VOCATIONAL REHABILITATION

30. If considered suitable, would you consent to a vocational rehabilitation assessment?

◯ Yes
◯ No **If no**, please explain.

31. Are you presently or have you ever been involved in a rehabilitation program?

◯ Yes **If yes**, please provide details.
◯ No

DECLARATION AND SIGNATURE

I realize that my personal information is governed by the *Privacy Act* and it can be disclosed where authorized under the Canada Pension Plan.

I agree to notify the Canada Pension Plan of any changes that may affect my eligibility for benefits. This includes: an improvement in my medical condition; a return to work (full, part-time, volunteer, or trial period); attendance at school or university; trade or technical training; or any rehabilitation.

Note: If you make a false or misleading statement, you may be subject to an administrative monetary penalty and interest, if any, under the *Canada Pension Plan,* or may be charged with an offence. Any benefits you received or obtained to which there was no entitlement would have to be repaid.

Signature of Applicant or Representative **X**	Date (YYYY-MM-DD)	Telephone Number

Use this space if required. Identify the number of the question the information belongs to.

RETURN THIS FORM WITH YOUR APPLICATION AND QUESTIONNAIRE TO SERVICE CANADA

Consent for Service Canada to Obtain Personal Information

Service Canada is authorized under Section 68 and 69 of the *Canada Pension Plan (CPP) Regulations* to receive personal (medical and non-medical) information about you to decide if you qualify or continue to qualify for CPP disability benefits. Your consent to permit Service Canada to obtain this information is necessary, should Service Canada need this information from persons and organizations listed on the following page.

Protecting your privacy:

Service Canada cannot give your personal information to any person or organization without your written consent, except where authorized by *CPP legislation*. Under the *Privacy Act*, you (or your authorized representative) have the right to request a copy of the information in your file and to request correction(s) to that information. Your personal information is retained in Personal Information Bank (ESDC PPU 146). Instructions for accessing this information are provided in the Info Source, a copy of which is located in Service Canada offices or at: **infosource.gc.ca**

Instructions:

- Complete Sections 1 and 2 of this form; and
- return this form with your application and questionnaire to **Service Canada**.

Section 1 - Client Information		
◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms.	Canadian Social Insurance Number	
First Name and Initial	Last Name	
Mailing address (No., Street, Apt. No., P.O. Box, R.R.)	City, Town or Village	
Province or Territory	Country	Postal Code
Telephone Number	Fax Number	

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Consent to obtain personal information

I give Service Canada my consent to obtain personal information about me that would help decide if I qualify or continue to qualify for Canada Pension Plan disability benefits. For this reason, Service Canada may contact any of the following persons and organizations if necessary:

- medical doctors, nurse practitioners, consultant specialists, or health-care professionals
- medical facilities or hospitals
- educational institutions or other vocational agencies
- my accountant or book-keeper for information on self-employment
- administrators of insurance plans
- federal, provincial, territorial, or municipal government departments and agencies
- employers, former employers
- provincial or territorial workers' compensation boards
- financial institutions - for address updates only

Section 2 - I give my consent or I do not give my consent

◯ I give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above. I understand that this information may help in determining if I qualify or continue to qualify for Canada Pension Plan disability benefits.

◯ I do not give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above.

I understand that my refusal means:

- that Service Canada will make a decision based on the available information on my file;
- if I am already receiving disability benefits, Service Canada may stop paying me the benefits; and
- under certain circumstances, Service Canada can require that I provide the necessary information (*CPP Regulations* and Pension Appeals Board Rules of Procedures).

Signature _____ Date of signature _____

Date (YYYY-MM-DD)

To be completed by witness if signed with a mark "X" or by a representative of the applicant

First Name and Initial	Last Name

Telephone Number

Signature _____ Date of signature _____

Date (YYYY-MM-DD)

This signed consent is valid for up to **3 years** unless you cancel it in writing. A photocopy or fax of this completed form is as valid as the original.

GIVE THIS FORM TO YOUR PHYSICIAN OR NURSE PRACTITIONER WITH THE MEDICAL REPORT

Consent for Service Canada to Obtain Personal Information

Service Canada is authorized under Section 68 and 69 of the *Canada Pension Plan (CPP) Regulations* to receive personal (medical and non-medical) information about you to decide if you qualify or continue to qualify for CPP disability benefits. Your consent to permit Service Canada to obtain this information is necessary, should Service Canada need this information from persons and organizations listed on the following page.

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Instructions:

- Complete Sections 1 and 2 of this form; and
- Give this form to **your physician or nurse practitioner** with the medical report.

Section 1 - Client Information		
◯ Mr. ◯ Mrs. ◯ Miss ◯ Ms.	Canadian Social Insurance Number	
First Name and Initial	Last Name	
Mailing address (No., Street, Apt. No., P.O. Box, R.R.	City, Town or Village	
Province or Territory	Country	Postal Code
Telephone Number	Fax Number	

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- administrators of insurance plans
- federal, provincial, territorial, or municipal government departments and agencies
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Signature _____ Date of signature _____ (YYYY-MM-DD)

To be completed by witness if signed with a mark "X" or by a representative of the applicant

First Name and Initial	Last Name

Telephone Number

Signature _____ Date of signature _____ (YYYY-MM-DD)

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